TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
James H. Posey, D.C.

**Respondent Name**
Texas Mutual Insurance Company

**MFDR Tracking Number**
M4-15-3719-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
July 13, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "… the payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines for the procedures billed."

**Amount in Dispute:** $800.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The date of service on the bill is 3/6/15 …

The exam date listed on the DWC69 is 5/30/14 …

The exam and certification dates are not substantiated by the billing dates."

**Response Submitted by:** Texas Mutual Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 6, 2015 | Designated Doctor Examination (MMI/IR) | $800.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.220 sets out the requirements for designated doctor reports.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.

- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT Code descriptions/instructions.
- Note: "DATE OF EXAM ON DWC 69 DOESN'T MATCH DATE OF EXAM ON REPORT."
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

**Issues**

Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

While CPT Code 99456-W6-RE was included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking $0.00 for this code; therefore, it will not be considered.

The insurance carrier denied disputed services with claim adjustment reason code "CAC-P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT," and "892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTION/INSTRUCTIONS."

The disputed services are billed using CPT Code 99456-W5-WP, representing a Designated Doctor Examination to determine Maximum Medical Improvement and Impairment Rating. 28 Texas Administrative Code §134.204 (j) states, in relevant part:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: …

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; …

Review of the submitted information finds that the designated doctor's report does not include a Report of Medical Evaluation (DWC069) for the date of service in question, in accordance with 28 Texas Administrative Code §127.220. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | Laurie Garnes | July 30, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.